Independence Plus
A Demonstration Program for Family or Individual Directed Community Services Waiver
§ 1915 (c) of the Social Security Act

Created by:

Center for Medicaid and State Operations

NOTE: This document has not yet received OMB approval of the information collection pursuant to the Paperwork Reduction Act.

STATE: North Dakota

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Template for *Independence Plus:* A Demonstration Program for Family or Individual Directed Community Services 1915(c) Waiver Application

I. State Proposal Information

The State of **North Dakota** requests approval of a Medicaid Home and Community-Based Services (HCBS) Waiver under the authority of Section 1915(c) of the Social Security Act. The program, to be entitled **North Dakota Self Directed Supports for Adults** will allow Medicaid beneficiaries to arrange and purchase family and individual supports and related services as described below. The proposed effective date of this waiver program is **April 1, 2006**. Initial waivers are approved for three years. Renewal waivers are extended for five years.

Line of Authority for Waiver Operation: (**Note**: The State Medicaid Agency is ultimately accountable for the operation of the program, but may allow daily operations to be managed by another entity of State government.) Check one:

X The waiver will be operated directly by the **Disability Services Division (DD Unit)** Unit of the State Medicaid Agency/Single State Agency.

_____ Operational management and responsibilities of the waiver will be carried out by _____ (another State Agency) and will be subject to an explicit interagency agreement that ensures for accountability and effective management for all requirements and assurances under this waiver. The single State Agency will retain the responsibilities of issuing policies, rules and regulations concerning this waiver. A copy of the interagency agreement setting forth the specific agency responsibilities and authorities is attached and is made pursuant to Section 1902(a) of the Act and 42 regulations at 42 CFR 431.10 which stipulates the roles and responsibilities of the single State Agency.

II. General Description of Program

The purpose of the program is to provide assistance for families with a member who requires long-term supports and services, or to individuals who require long-term supports and services, so that the individual may remain in the family residence or in their own home. Eligibility will be limited to those individuals who require long-term supports at a level typically provided in an institution, as specified in this application.

The State has the flexibility to define a range of community-based services that will support families and individuals. Families and individuals will work with the State to identify, through a family or person-centered planning process, those services and supports needed to avoid placement in an institutional setting or placement in group living arrangements of greater than four persons. The State will maintain the ability to control costs and, in conjunction with individuals or families, establish mutual expectations regarding available resources. These resources will be identified through an established methodology, open for public inspection, for determining an individual budget that would be based upon actual service utilization data. Through the provision of services and supports identified through the plan of care and the

operation of a quality assurance and improvement program, the State will ensure the health and welfare of the individuals in the program. In addition, the program will provide assurances of fiscal integrity and include participant protections that will be effective and family-friendly. (Additional information, specific to the State administration is included in Appendix A.)

III. Assurances

The State provides the following assurances to CMS:

Health & Welfare - Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards are described in **Appendix B** and include:

A. Adequate standards for all types of providers that furnish services under the waiver;
B. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that is provided under the waiver. The State assures that these requirements will be met on the date that the services are furnished; and
C. Assurance that all facilities covered by Section 1616(e) of the Social Security Act, in which Home and Community-Based Services will be provided, are in compliance with applicable State standards for board and care facilities.

Check one:

__**X**__ Home and Community-Based Services will not be provided in facilities covered by Section 1616(e) of the Social Security Act.

_____ A list of facilities covered by 1616(e) of the Social Security Act, in which HCBS are furnished, and a copy of the standards applicable to each type of facility identified above are also maintained by the Medicaid Agency. These facilities will be used for the limited purpose of:_____
(Note: For example, respite care only when other services are unavailable.)

Financial Accountability - The State will maintain the financial integrity of the HCBS Waiver program. The State will assure financial accountability for funds expended for Home and Community-Based Services and will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted. **See Appendix G-3**.

Evaluation of Need - The State will provide for an evaluation (and periodic reevaluations, at least annually) of the individuals' need for an institutional level of care, when there is a reasonable indication that individuals might need such services in the near future (one month or

less) but for the availability of Home and Community-Based Services. The requirements for such evaluations and reevaluations are detailed in **Appendix D**.

Choice of Alternatives - When an individual is determined to require a level of care provided in a NF, hospital, or ICF/MR, the individual or his or her legal representative will be:

A. Informed of any feasible alternatives under the waiver; and
B. Given the choice of either institutional or Home and Community-Based Services.

The State will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care, or whose services are denied, suspended, reduced or terminated.

Average per capita expenditures - The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care, for which this waiver is an alternative, under the State plan that would have been made in that fiscal year had the waiver not been granted. Cost neutrality is demonstrated in **Appendix G**.

Actual total expenditures - The State's actual total expenditures for Home and Community-Based Services and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) for which this waiver is an alternative in the absence of the waiver. Cost neutrality is demonstrated in **Appendix G**.

Services absent the waiver - Absent the waiver, participants would receive the services appropriate to the level of care typically provided in institutional settings available through the State plan.

Reporting - The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the waiver and on the health and welfare of the persons served through the waiver. The information will be consistent with a data collection plan designed by CMS. Reporting is described in **Appendix F-2**

IV. Waivers Requested

Statewideness: The State requests a waiver of the "Statewideness" requirements set forth in Section 1902(a)(1) of the Act.

__**X**__ No. Services will be available Statewide.

___ Yes. Waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

_____

_____

Comparability: The State requests a waiver of the requirements contained in Section 1902(a)(10)(B) of the Act, to provide services to individuals served on the waiver that are not otherwise available to other individuals under the approved Medicaid State plan.

Income and Resources: The State requests a waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act in order to use institutional income and resource rules for the medically needy.

__**X**__ Yes _____ No _____ N/A

V. State Specific Elements

A. Levels Of Care: This waiver is requested to provide Home and Community-Based Services (HCBS) to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan: (check all that apply)

_____ Hospital
_____ Nursing Facility
__**X**__ ICF/MR

B. Target Population: A waiver of Section 1902(a)(10)(B) of the Act is requested to limit Home and Community-Based Services waiver services to select groups of individuals who would be otherwise eligible for waiver services. The target groups are indicated below:

1. Target group per 42 CFR 441.301(b)(6) – Check all disability and age categories that apply. (**Note:** Current regulations governing 1915(c) waivers do not allow persons under age 65 with mental retardation or developmental disability – and no concurrent physical disability – to be served in a waiver that serves persons with physical disabilities only. Combining populations under the 1115 Demonstration authority is allowable.)

Category	**CHILDREN AGE RANGE**		**ADULTS AGE RANGE**		**AGED AGE RANGE**
	From	**To**	**From**	**To**	**From**
Aged only					
Disabled (Physical)					
Disabled (Other)					
Brain Injury (Acquired)					
Brain Injury (Trauma)					

HIV/AIDS					
Medically Fragile					
Technology Dependent					
Autism					
Developmental Disability			**21**	**Over**	
Mental Retardation			**21**	**Over**	
Mental Illness					

2. States have the discretion to further define these target groups. If the State wishes to further define, please describe below:

3. The State selects the following option regarding individual cost limits:

_____A. No otherwise eligible individual will be denied services or enrollment in the waiver solely because the cost of the individual's Home and Community-Based Services exceeds the average institutional Medicaid payment for the applicable level of care.

__**X**___ B. Otherwise eligible individuals may be denied home or community-based services if the agency reasonably expects that the cost of the Home and Community-Based Services would exceed the cost of an equivalent and applicable level of institutional care, pursuant to 42 CFR 441.301(a)(3). The State selects the following method to calculate these costs:

_____ **Individualized Computation.** The Medicaid cost of the individual's service plan is compared to the cost of serving *this particular individual* in the institutional setting.

__**X**____ **Mathematical Average.** The Medicaid cost of the individual's service plan will be compared to the state's average per capita cost of applicable institutional care at

__**X**__ 100% of the institutional average or a level higher than 100% (_____%). Further, the limit will be calculated on the basis of:

_____ **1) Level of care**

_____ 2) Diagnosis or condition

C. Medicaid Eligibility: All eligibility groups included under this waiver are covered in the State plan. The State will apply all applicable FFP limits under the plan.

1. ***Eligibility Criteria***: Specify whether your State uses the eligibility criteria used by the Supplemental Security Income (SSI) program or whether it uses more restrictive eligibility criteria than those of the SSI program for aged, blind, and disabled individuals: (check one):

   ____ SSI Criteria or 1634 State. The State uses SSI criteria.

   _X_ 209(b) State. The State uses more restrictive eligibility criteria for aged blind, and disabled individuals than the criteria used under the SSI program.

2. ***Eligibility Groups Served*:** Individuals receiving services under this waiver are eligible for Medicaid under the following eligibility groups: (check one):

   a. X All eligibility groups covered in the State plan are included under this waiver.

   b. ___ Only the following groups covered under the State plan are included under this waiver. (Check all that apply)

   1. _____Low-income families with children as described in Section 1931 of the Social Social Security Act
   2. _____ SSI Recipients
   3. _____Aged, blind or disabled who are eligible under 42 CFR 435.121
   4. _____Medically needy (A waiver of Section 1902(a)(10)(C)(i)(III) of the Social Security Act is requested to use institutional income and resource rules for the medically needy.)
   5. _____ All other optional and mandatory groups under the plan except for those individuals who would be eligible for Medicaid only if they were in an institution).
   6. _____ Individuals who would be eligible for Medicaid only if they were in an institution
   7. _____ Individuals who would only be eligible for Medicaid, without spend down income, if they were living in a hospital, NF or ICF/MR. (Check one)
      _____ All Individuals
      _____ Limited to:
      A special income level equal to:
      _____300% of the SSI Federal Benefit Rate (FBR), OR
      _____ %, a percentage lower than 300% of FBR, OR
      $____, a specific amount that is lower than 300% of FBR

_____ Aged blind and disabled who meet requirements that are more restrictive than those in the SSI program
(Please explain:_____
_____
_____ Medically needy without spend down
_____Other:

3. Spousal Impoverishment Protection: Spousal impoverishment rules may be used for determining eligibility for the special Home and Community-Based Waiver eligibility group at 42 CFR 435.217 for individuals who have a spouse residing in the community. Further, these rules may apply to the post-eligibility treatment of income.

The State will use spousal impoverishment rules for determining income:
_____ Yes __**X**__ No

The State will use spousal impoverishment rules for the post-eligibility treatment of income:
_____ Yes __**X**__ No

D. Services: The State requests that the following Home and Community-Based Services, as set forth in 42 CFR 440.180, be included under this waiver (Check all that apply here and define in **Appendix B**): (**NOTE:** All services must meet applicable regulatory standards and CMS policy guidance. Refer to **Appendix B** for new self-directed service descriptions.)

Check all that apply:

Service	**Family or Individual Directed Method**	**Provider or Other Service Delivery Method**
Case Management		
Homemaker Services		
Home Health Aide Services		
Enhanced Personal Care Services (may include Attendant Care)		
Adult Day Health Services		
Habilitation Services		
Respite Services		
Supports Brokerage Services/Functions (Required)		**Will Claim as Administrative Cost**

Fiscal/Employer Agent Services/Functions (Required)		**Will Claim as Administrative Cost See Fiscal Agent Attachment**
Other (Describe in Appendix B)	**X**	**X**

VI. Cost neutrality

The State has provided the supporting information/data to demonstrate cost neutrality in **Appendix G**.

VII. Additional Requirements

A. Plan Of Care: A written plan of care will be developed for each individual under this waiver utilizing a family or person-centered planning process that reflects the needs and preferences of the individual and their family. The State's procedures governing the plan of care and the utilization of family or person-centered planning are included in **Appendix E**.

(**Note**: Family or person-centered planning is a process, directed by the family or the individual with long-term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or individual directs the family or person-centered planning process. The process includes participants freely chosen by the family or individual who are able to serve as important contributors. The family or person-centered planning process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified, including medical and professional staff. The identified personally-defined outcomes and the training, supports, therapies, treatments and/or other services the individual is to receive to achieve those outcomes become a part of the plan of care.)

All services will be furnished pursuant to a written plan of care.

This plan of care will describe the services and supports (regardless of funding source) to be furnished, their projected frequency, and the type of provider who will furnish each.

The plan of care will address how potential emergency needs of the individual will be met.

The plan of care will be subject to the approval of the Medicaid Agency.

FFP will not be claimed for waiver services furnished prior to the development of the plan of care or services that are not included in the individual written plan of care.

B. Individual Budgets:

(**NOTE:** Individual budgets include the value of the waiver services available to the family or individual to support the individual's plan of care. Only waiver services as defined by the State are included in the individual budget. This amount of money designated in the budget is established by a methodology determined by the State and the amount is agreed upon with the family or individual.)

Check one:

__**X**__ The State has established a uniform methodology by which all individual budgets in the State will be calculated. The methodology is described in **Appendix H**. (**Note**: Minimum requirements of the methodology are that the budget is built upon actual service utilization and cost data, the methodology is described to the individual and their family, the methodology is open for inspection by authorized public entities including, but not limited to CMS, and there is a process for re-determination.)

_____ The State has established a minimum set of criteria and an approval process for methodologies developed by subcontractors, counties or other entities with which the State has contracted for the day-to-day operation of the waiver. The criteria by which individual budget methodologies will be reviewed and the approval process is described in **Appendix H**. (**Note**: Minimum requirements of the methodology are that the budget is built upon actual service utilization and cost data, the methodology is described to the individual and their family, the methodology is open for inspection by authorized public entities including, but not limited to, CMS, and there is a process for re-determination. Although the Medicaid Agency may contract with another agency or organization for the daily operation of the waiver program, it must retain the authority to issue policies, rules and regulations related to the waiver.)

C. Provider Selection: Families and individuals will have flexibility to select qualified providers of their choosing within the criteria established by the State. The criteria are described in **Appendix B.**

D. Plan Of Care Management: Families and individuals will have the ability to direct the services and supports identified in the plan of care within the resources available in the established individual budget. Families will have maximum possible flexibility in the

utilization of resources delineated in the plan of care and individual budget. The State's description of how families may flexibly use resources while the State continues to assure health and welfare is described in **Appendix E**.

(Note: As determined by the state, families and individuals may have the ability to move resources among and between all or some of the services contained in the plan of care without a formal plan of care revision. Families or individuals might have full discretion to manage all of the plan or only parts of it. For example, the family or individual might manage the homemaker services, but not the habilitation services.)

E. Participant Protections: The State assures that each of the protections below is in place and described in **Appendix I**.

The State has procedures to assure that families have the requisite information and/or tools to participant in a family or person-centered planning approach and to direct and manage their care as outlined in the individual plan of care. The State will make available and provide services such as assistance in locating and selecting qualified workers, training in managing workers, completing and submitting paperwork associated with billing, payment and taxation. Supports Brokerage and Fiscal/Employer Agent Services/Functions are required and should be provided by one or more entities. The services and the provider qualifications are described in **Appendix B**.

Upon family or individual request, the State makes available, at no cost, provider qualification checks, including criminal background checks. (Note: Provider qualifications for each service are described in **Appendix B**.)

The State has procedures to promote family and individual preferences and selections and these are appropriately balanced with accepted standards of practice. This balance requires deference to the individual whenever possible. Procedures will include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

The State has a viable system in place for assuring emergency back-up and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the State also has system procedures in place.

The State has procedures for how it will work with families or individuals and their fiscal/employer agents (if applicable) to monitor the ongoing expenditure of the individual budget.

The State has procedures for how it will handle those instances where this ongoing monitoring has failed to prevent the expenditure of the individual budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the health and welfare of the individual are available.

The State has procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination.

F. Quality Assurance & Improvement:

The State, through an organized quality assurance program, will provide appropriate oversight and monitoring of its HCBS Waiver program to ensure that each of the assurances contained in this application is met and to continually improve the operation of the program. The program will involve families or individuals in the process of assessing and improving quality. Details of this process are found in **Appendix F** of this request. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with their severity and nature and will contain an incident management system to address critical events.

Contact Person: The State Medicaid Agency Representative that CMS may contact with questions regarding the waiver request is:

Name: **Michael Marum**
Title: **Administrator**
Agency: **Disability Services Division, Developmental Disabilities Unit**
Address: **1237 West Divide Avenue, Ste. 1A, Bismarck, ND 58501**
Telephone: **(701) 328-8977**
E-mail: **somarm@state.nd.us**

G. Authorizing Signature: This document, together with Appendices A through I, and all attachments, constitutes the State's request for a *Independence Plus:* A Demonstration Program for Family or Individual Directed Community Services Home and Community-Based Services Waiver under Section 1915(c) of the Social Security Act. The State affirms that it will abide by all conditions set forth in the waiver (including Appendices and Attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid Agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide Home and Community-Based Services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid Agency.

(**Note:** The request must be signed by the Governor, Single State Agency or Medicaid Director, or a person within the State Medicaid Agency with the authority to sign on behalf of the State.)

Signature:

Print Name:

Title:

Date:

APPENDIX A – DESCRIPTION OF THE WAIVER PROGRAM

(**Note:** The state must provide a narrative description of the waiver program beyond the general description above. This includes the intended purposes of the waiver.)

The North Dakota Self Directed Supports for Adults program offers eligible individuals and their families the opportunity to direct a fixed amount of public resources in a flexible manner that is meaningful and helpful in achieving their personally defined goals. North Dakota's Self Directed Supports program is based upon the belief that in order for eligible individuals with disabilities and their families to fully participate in their community, they must define the life they seek and be supported as they direct a mixture of generic and formal supports that will help them achieve their personally defined outcomes.

Person centered planning is a critical foundation on which self-directed supports are built. Person-centered planning is based on the belief that the eligible individual and their family knows their needs and interests better than the professionals and para-professionals who come and go throughout that person's lifetime. Through person centered planning the eligible individual and their family identify and express their personal needs, wishes, and aspirations. A variety of supports can then be explored with the assistance of a DD Case Manager/Support Broker. The supports may range from the informal support of family and friends, to generic community supports available to all, to formal paid supports offered through the Department of Human Services.

Self-directing supports involves sharing responsibility and risk. As eligible individuals and families exercise greater choice and control over the supports they receive, they also assume relevant responsibility and accept reasonable risk associated with the decisions that they make. DD Case Managers/Support Brokers will provide educational material to eligible individuals and families regarding their roles and responsibilities in self-directing supports.

North Dakota's Self Directed Supports program is designed to:

A. Promote access by eligible individuals to needed services and supports.
B. Provide supports that are adequate to assure the general health and safety of eligible individuals.
C. Maintain the health and independent living skills of eligible individuals to allow them to remain in their community residence.
D. Provide supports for eligible individuals to live as independently as possible in the community settings of their choice.
E. Improve eligible individuals access to multiple community environments.
F. Promote the inclusion of people with disabilities in the activities and environments of their communities.
G. Foster mutually beneficial relationships among eligible individuals and people who do not have disabilities and who are not paid care givers for the purposes of expanding the natural support networks of waiver recipients and allowing waiver recipients to occupy socially valued roles in their communities.

H. Improve the eligible individuals ability to perform activities of daily living and thereby achieve greater independence from caregivers.

I. Provide the array of supports that allow the eligible individuals to demonstrate progress towards their valued outcomes.

J. **Purchase supports that are cost effective. Eligible individuals and families will receive adequate and appropriate services and supports. Whenever there are multiple, acceptable support options, waiver funding will be used to purchase the most cost effective among those options**.

K. Provide supports that provide a clear benefit to the consumer.

L. Purchase supports only after supports available through the Medicaid State Plan and all other resources for which the individual is eligible have been maximized. Supports purchased with waiver funding will not be duplicative of each other or of supports purchased by other funding sources, public or private.

M. **Allow eligible individuals or their legal representative to define the family home setting in which the eligible individual is supported by a primary caregiver.**

APPENDIX B - SERVICE DEFINITIONS, STANDARDS AND PROVIDER QUALIFICATIONS

A. SERVICE DEFINITIONS, STANDARDS & PROVIDER QUALIFICATIONS CHARTS

For each service that was checked under State Specific Elements/Services of the template, the following chart must be completed. Each chart provides the State's service definition, outlines the provider qualifications and standards, and the service delivery method that govern the provision of each service under the waiver.

Provider qualifications would be expected to vary by the type of service being provided or managed. For those services for which there is a uniform State license or certification requirement, the legal citation is provided. For State defined standards other than those governed by State law, the standards are attached. Either the family or individual and the State Agency may manage some services. For example, the family or individual might have self-directed support services which include personal care type arrangements. The State may also have personal care services provided by an agency. The provider requirements might be different under these two arrangements. However, the differences must be explained.

For those services that are available in the State plan, the description must include those aspects of the service that go beyond the State plan coverage. (**Note:** For example, if personal care services are included in the State plan, personal care services provided under the scope of the waiver must differ in amount, scope, supervision arrangements or provider type **or** be utilized only when the state plan coverage is exhausted.)

The State has the authority to request that the Secretary approve "other" services identified by the State as cost neutral and appropriate to avoid institutionalization. Each "other" service defined by the State must be separately identified and defined and include the provider qualifications.

Service/Function Definitions Not Described Elsewhere:

> ***Case Management/Supports Brokerage:*** Service/function that assists participating families and individuals to make informed decisions about what will work best for them, are consistent with their needs and reflect their individual circumstances. Serving as the agent of the family or participant, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. A family or person-centered planning approach is used. Supports Brokerage offers practical skills training to enable families and individuals to remain independent. Examples of skills training include providing information on recruiting and hiring personal care workers, managing personal care workers and providing information on effective communication and problem solving. The service/function provides sufficient information to assure that participants and their families understand the responsibilities involved with self-direction and assist in the development of an effective back-up and emergency plan. States

may elect to fulfill the requirement of this service/function using a self-directed case manager or creating a distinct service. States may elect to fulfill this required service/function either as a service cost or an administration cost, but must clearly identify which method will be used. The services/functions included in Supports Brokerage are mandatory requirements of the template.

Fiscal/Employer Agent: Service/function that assists the family or individual to manage and distribute funds contained in the individual budget including, but not limited to, the facilitation of the employment of service workers by the family or individual, including Federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, etc. States may elect to fulfill this required service/function either as a service cost or an administration cost, but must clearly identify which method will be used. This service/function, regardless of provider or method, must be delivered under a family or person-centered planning process and is a requirement of the template.

Other Services: Services appropriate to ensure the health and welfare of individual participants and, in conjunction with other services, serve as an alternative to institutionalization.

Service Title	**Self Directed – In Home Supports**
Service Definition	Self Directed – In Home Supports (SD-IHS) enables an individual with a disability, who so desires, to remain in and be supported in their family home and community. SD-IHS is intended to support both the family member with a disability and the rest of the family to live as much like other families as possible with the intent of preventing or delaying unwanted out of home placement. The eligible client must be living with a family member who is their primary caregiver. SD-IHS benefits the eligible client by supporting their primary caregiver in meeting the needs of the eligible client. The primary care giver is supported in meeting the following needs of their family member with a disability within the routines of a family: • Training as identified in the Person Centered Plan • Physical or verbal assistance to complete activities such as eating, drinking, toileting and physical functioning; improving and maintaining mobility and physical functioning; maintaining health and personal safety; carrying out household chores and • Preparation of snacks and meals; communicating, including use of assistive

	technology; learning to make choices, to show preference, and to have opportunities for satisfying those interests; developing and maintaining personal relationships; pursuing interests and enhancing competencies in play, pastimes and avocation • Involvement in family routines and participation in community experiences and activities SD-IHS is also available to provide the primary caregiver temporary relief from the demands of supporting their family member with a disability. The eligible client will be supported in the home in which they live or in another home setting approved by the legal decision maker. SD-IHS supports will not be delivered in group residential settings.
Provider Requirements	An independent provider will be required to: • Be at least 18 years of age, • Identify two former employers and give permission for reference checks, if requested, • Agree to undergo a criminal background check; • Sign affidavits regarding: • Incident reporting, abuse/neglect/exploitation; • Confidentiality; • Person Centered Plans; and • Respect and Rights; • Complete a Self Declaration regarding Infectious and Contagious Diseases; and • Demonstrate competencies as identified in the Person Centered Plan. The individual/family may also co-employee a provider who is employed by a Licensed DD Provider according to NDAC 75-04-01. The employee of the Licensed DD Provider would be required to: • Demonstrate competencies as identified in the Person Centered Plan.
State License	A state license is required for an agency provider.
Certification	None.
Other Requirements or Standards	Competencies that providers must display will be determined through the person centered planning process and documented in the individual's Case Plan. The primary caregiver will determine if the employee they hire has the identified competencies.
Describe Service Delivery Method (Agency or Self-directed)	The individual/family will self-direct SD-IHS supports. The DD Case Manager/Support Broker will provide informational material to the individual/family regarding the roles and responsibilities of self-directing supports. The individual/family, DD Case Manager/Supports Broker, and others identified by the individual/family will complete a person center planning process to identify the personal needs and wishes of the

	individual/family and document such in the individual's Case Plan. An Individual Budget will be developed by the individual/family with their DD Case Manager/Supports Broker based on the needs identified in the individual's Case Plan. The individual, natural or legally appointed guardian will determine what provider will provider SD-IHS. The legal decision maker will select a provider that meets basic provider qualification. A Fiscal Agent under contract with the North Dakota Department of Human Services will complete employment related documentation for the provider(s) identified/selected by the individual/family including execution of provider agreements in accordance with Medicaid agency's standards as authorized by the State, process payments for the identified vendors/providers based on records submitted by the eligible individual/family, and submit appropriate billings to the ND DHS as allowed for in the individual budget.
Service Title	**Employment Supports**
Service Definition	Ongoing on the job support and intervention necessary for an individual with a disability to maintain employment and for whom competitive employment at or above minimum wage is unlikely without the support and intervention. Support and intervention do not include normal employee orientation and training normally provided to all employees. Support and interventions include assuring health and safety, integration into the workplace, assistance with on the job interpersonal relations, and training and supervision beyond that normally provided by the employer. The ongoing job support and intervention in this service does not include services available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142.

Provider Requirements	An independent provider will be required to:
	• Be at least 18 years of age,
	• Identify two former employers and give permission for reference checks, if requested,
	• Agree to undergo a criminal background check;
	• Sign affidavits regarding:
	  • Incident reporting, abuse/neglect/exploitation;
	  • Confidentiality;
	  • Person Centered Plans; and
	  • Respect and Rights;
	• Complete a Self Declaration regarding Infectious and Contagious Diseases; and
	• Demonstrate competencies as identified in the Person Centered Plan.
	
	A DD provider licensed according to NDAC 75-04-01 would be required to:
	• Demonstrate competencies as identified in the Person Centered Plan

State License	A state license is required for a provider agency.
Certification	None

Other Requirements or Standards	Requirements of independent providers will be determined by the waiver participant and their person centered planning team.
Describe Service Delivery Method (Agency or Self-directed)	The individual/family will self direct the independent provider selected by the participant and his/her planning team. An independent provider may include a coworker, who with the cooperation of the employer agrees to the responsibility and is adequately trained to the participants job support needs and is compensated for this responsibility. A Fiscal Agent under contract with the North Dakota Department of Human Services will complete employment related documentation for the provider(s) identified/selected by the individual/family including execution of provider agreements in accordance with Medicaid agency's standards as authorized by the State, process payments for the identified vendors/providers based on records submitted by the eligible individual/family, and submit appropriate billings to the ND DHS as allowed for in the individual budget.

Core provider qualification will be monitored by the Fiscal Agent. DD Case Managers/Support Brokers will review individualized competencies identified through the Person Centered Planning Process when completing quarterly contacts with consumers/families and document results in Quality Enhancement Reviews.

B. ASSURANCES THAT REQUIREMENTS ARE MET

1. The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

2. The State assures that each service furnished under the waiver is cost-effective (compared to the cost of institutional care) and necessary to prevent institutionalization. Cost effectiveness is demonstrated in **Appendix G.**

C. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX C- INTENTIONALLY LEFT BLANK

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

Persons performing initial evaluations of level of care for waiver applicants will have the following educational/professional qualifications:

The minimum qualifications for a Case Manager II are: a) the equivalent of a bachelor's degree in social work, psychology, child development and family relations, special education, vocational rehabilitation or a closely related field and one year of experience working with the developmentally disabled; or a master's degree in counseling and guidance, or one of the above listed behavioral sciences including coursework in developmental disabilities. The minimum qualifications for a Case Manager III are two years experience as a Developmental Disabilities Case Manager II in the North Dakota Department of Human Services.

b. PROCESS FOR LEVEL OF CARE DETERMINATION
The following describes the process for evaluating and screening waiver applicants to determine level of care:

The appropriate regional DD Case Manager completes an evaluation or reevaluation of each eligible individual on at least an annual basis. A computer based Progress Assessment Review (PAR) and ICF-MR Guidelines are used. A copy of each completed PAR is maintained within the ASSIST computerized case management system for at least three years. This computerized evaluation/reevaluation system is scored electronically within the system and relates a score back to the DDCM indicating if minimum criteria has been met.

c. CONSISTENCY WITH INSTITUTIONAL LEVEL OF CARE
The State will use the following methods to ensure that level of care determinations used for the waiver program are consistent with those made for institutional care under the State plan:

DD Case Managers perform the level of care for waiver and ICF/MR services.

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at least annually) according to the following schedule: **Every 12 months.**

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Persons performing reevaluations of level of care will have the following qualifications:

The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of **c**are:

Alerts in the ASSIST computer system.

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s**):**

Regional Human Service Centers (DD Unit) and electronic file in ASSIST.

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

Records are kept in electronic file for at least three years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION / ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix. If this instrument differs from the form used to evaluate or assess institutional level of care, a description of how and why it differs and an assurance that the outcome of the determination is reliable, valid, and fully comparable is attached.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care provided in an institutional setting, the individual or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

b. given the choice of either institutional or Home and Community-Based services.

PROCESS: The following describes the agency's procedure(s) for informing eligible individuals of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services:

The DDCM/Support Broker must inform the individual and/or legal representative of the following assurances prior to the development and signing of each Individual Service Plan (ISP). The individual and/or legal representative signature on the ISP means that they acknowledge the following: a) they received a copy of their rights; b) they have been informed of their right to select institutional services or waiver services, c) they were informed of their right to a choice of service provider(s); d) they received information regarding their right to appeal; e) they are in agreement with the services listed on the ISP.

Regional Human Service Centers where Case Managers are employed have established procedures to access interpreter services for spoken and written communication. This support is available through out the intake and service delivery process.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care or who are denied the service(s) of their choice, or the provider(s) of their choice.

PROCESS: The following describes the process for informing eligible individuals of their right to request a fair hearing under 42 CFR Part 431, Subpart E:

When an individual meets the criteria for ICF/MR level of care, the DD Case Manager/Support Broker must inform the individual or his or her legal representative of the following: a) any feasible alternative available under the waiver and, b) give the choice of either ICF/MR or Home and Community Based Waiver Services and, c) informed of their right to choice of waiver service providers and, d) the right to request a fair hearing under 42 CFR part 431, Subpart E, if the consumer or legal representative is not given the choice of home or community based services as an alternative to the institutional care, if denied a service(s) of choice or the provider of choice.

b. FREEDOM OF CHOICE DOCUMENTATION

1. A copy of the form(s) used to document freedom of choice and to offer a fair hearing is attached to this Appendix.

2. Copies of free choice documentation are maintained in the following location(s):

In the Lotus Notes ASSIST Documentation database. A signed copy of the ISP is maintained in the Human Service Center client file.

APPENDIX E - PLAN OF CARE

APPENDIX E-1 - PLAN OF CARE DEVELOPMENT/MAINTENANCE

1.The attached policy and procedures define and guide the family or person-centered planning process and assure that families are integrally involved in the plan development and that the plan of care reflects their preferences, choices, and desired outcomes.

The development of individual plans of care/Case Plans will be based on the guiding principles of individual and family involvement and consumer choice and control Service planning/Case Planning will be a personalized, interactive and ongoing process to plan, develop, review and evaluate the services in accordance with the preferences and desired outcomes of the individual/family.

The DD Case Manager/Support Broker will maximize the extent to which an individual/family participates in the service planning by:

- **Explaining to the individual/family the Case Plan/person centered planning process**
- **Assisting the individual/family to explore and identify their preferences, desired outcomes, goals, and services and supports that will assist them in achieving their outcomes; and**
- **Identifying and reviewing with the individual/family issues to be discussed during service planning/Case Planning meetings.**
- **Giving each individual/family an opportunity to determine the location and time of Case Plan meetings; participants in the Case Plan meeting; and number of meetings and length of meetings.**

A Case Plan meeting will be arranged for each individual/family prior to the delivery of services. The Case Plan will be developed jointly by the individual/family, DD Case Manager/Support Broker, and/or consultants, providers and others chosen by the individual/family who are involved in the life of the individual/family.

A written individualized Case Plan will be developed, documenting:

- **The desired outcomes of the individual/family,**
- **Generic, natural services/supports that will assist the individual/family in achieving their outcomes regardless of funding source**
- **Authorized services and supports available through the Department of Human Service that will assist the individual/family in achieving their outcomes**
- **Objectives and activities associated with the outcome and specific roles and responsibilities of all parties including:**
- **Specific documentation requirements regarding delivery of services and activities performed**

- **Description of how the authorized services will integrate other related support plans such as an individual education plan, behavioral plan etc and be consistent with other services provided in other environments such as community and school**
- **Risk management and emergency /contingency plans on how the essential health and safety needs of the individual will be met in the event the primary care givers are not available or provider of supports are not available.**
- **Anticipated Amount, unit and frequency /schedule of service or support.**
- **Start date of the authorized service in the authorization period**
- **End date of the authorized service in the authorization period**
- **Termination date of services, if applicable**

After the Person Centered Planning process has determined the outcomes desired and the supports needed to achieve those outcomes, the DD Case Manager develops an individual budget with the individual/family for the Self Directed Supports authorized to support the outcomes. ASSIST, the North Dakota DD Case Management electronic database, is constructed to require that outcomes be developed before services are identified to support the outcome. Service must then be associated with the outcomes that they will support before the Case Plan can be made active. ASSIST Case Plans must be activated before the data can be transferred from ASSIST to authorize payment through MMIS when an individual budget is approved. A separate database allows DD Case Managers to develop quarterly individual budgets, which are then processed through an automated work flow feature that allows Regional DD Program Administrators and then Department of Human Services central office staff to review and document approval or disapproval in a timely manner. Information from approved individual budgets is then forwarded for entry to allow payment through MMIS, if Medicaid eligibility and level of care screenings are also in place.

Within 14 days following a Case Plan meeting, the DD Case Manager/Support Broker will complete the written Case Plan and provide the individual/family a copy of the plan.

The individual/family will have the responsibility to initiate a Case Plan meeting by contacting the DD Case Manager/Support Broker when a Case Plan is not being carried out, when a change in service is desired or when a crisis develops.

The Case Plan may be amended at any time by the individual/family, and DD Case Manager/Support Broker through joint discussion/written revision and consent as shown by signature of the individual/family.

2. The following individuals are responsible for the preparation of the plans of care:

   1) Individual/family
   2) DD Case Manager/Support Broker

3) Anyone else requested by the individual/family including the provider of service, other family members, friends, consultants etc.

3. Copies of written plans of care will be maintained for a minimum period of 3 years in the following locations:

   The Regional Human Service Center electronic file in (ASSIST).

4. The plan of care is the fundamental tool by which the State will ensure the health and welfare of individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability, and responsive to the individual's needs and preferences. The minimum schedule under which these reviews will occur is:

   The DD Case Manager/Support Broker will review the identified outcomes in the Case Plan and the individual/family's satisfaction with services on a quarterly basis (every 3 months) through a documented face to face visit with the individual/family. This is accomplished through the Quality Enhancement Review.

5. If the State uses a standardized plan of care document, a copy of this form should be submitted.

   See attached Case Plan and QER

APPENDIX E-2 – MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid Agency.

The case plan is developed jointly between the eligible individual with developmental disabilities and the regional DD Case Manager/Support Broker, an employee of the Medicaid State Agency.

APPENDIX E-3 – PLAN OF CARE MANAGEMENT

The following is a description of process and parameters within which families or individuals have flexibility to utilize resources identified within the plan of care and the individual budget that do not necessitate a formal revision to the plan of care. In addition, the State's infrastructure to support families or individuals in directing and managing their plan of care is described here.

The North Dakota Self Directed Supports program offers eligible individuals and their families the opportunity to direct a fixed amount of public resources in a flexible manner that is meaningful and helpful in achieving their personally defined goals. The Individual

Budget will be negotiated on a quarterly basis to support the outcomes identified in the individual's Case Plan. The budget will be authorized for a 3-month period during which time the individual/family will have flexibility to exercise choice and control in utilizing and managing the resources authorized to meet the outcomes identified in their Case Plan. The individual/family will have the ability to transfer funds from a service area/line item to other service areas/line items within their budget as long as individual budget area limitations and the total budget amount for the authorized period is not exceeded. If the individual/family wish to access additional funds or utilize funds to support an outcome not addressed in their current budget, they will need to notify their DDCM/support broker and request a Case Plan review and budget revision. The budget revision must be approved prior to expending funds.

We are currently working with the North Dakota Center for Persons with Disabilities through Minot State University to develop training material for families and Support Brokers. The material will be finalized once our waiver application is approved. Consumers must approve and sign Individual Budgets and addendums to those budgets. They will receive a copy of the budget or addendum, in addition to monthly updates of the expenditures and their remaining balance from the Fiscal Agent.

Individual Budgets will be 'individualized' based on consumer needs, but will not be approved in excess of service utilization limits unless an exception is approved as stated in Appendix H.

APPENDIX F – QUALITY ASSURANCE AND IMPROVEMENT

APPENDIX F-1 - QUALITY ASSURANCE & IMPROVEMENT PROGRAM

A description of the State's quality assurance and improvement program is attached. This description includes State policies and procedures which describe the:

1) frequency of quality assurance activities;
2) domains/dimensions/assurances that will be monitored (e.g., access, person-centered service planning, provider capacity and capabilities, participant safeguards, participant rights, participant outcomes and satisfaction, etc.);
3) process of discovery (including sampling methodologies and whether or not information is collected from interviews with families/individuals in their community residences);
4) identification of the persons responsible for conducting quality assurance activities and their qualifications (including how families and individuals will be involved in the process of assessing and improving quality);
5) provisions for periodically reviewing and revising its quality assurance policies and procedures when necessary;
6) provisions for assuring that all problems identified by the discovery process will be addressed in an appropriate and timely manner, consistent with the severity and nature of deficiencies and
7) system to receive, review and act upon critical events or incidents.

Under North Dakota's Self-Directed Services Waiver, the DD Case Manager/Support Broker has primary responsibility for conducting quality assurance activities. The DD Case Manager/Support Broker is a qualified mental retardation professional (QMRP). The DD Case Manager/Support Broker will conduct a visit with the individual/family at their residence each quarter (90 days) to review:

- **the status of identified outcomes,**
- **the individual/family's satisfaction with services and supports**
- **significant events that have occurred and have impacted the individual's/family quality of life including but not limited to: illnesses/hospitalizations, major medication changes or health issues, change in family composition, change in residence, job or school setting, results of new evaluations or assessments;**
- **critical incidents related to the health and safety of the individual including, but not limited to: serious injuries, self-preservation issues, risk management needs, abuse, neglect or exploitation or rights issues.**

The results of the visit will be documented in the Quality Enhancement Review . Any problems that are identified will be addressed in an appropriate and timely manner.

The success of the Self-directed Services waiver depends upon individuals and their families. Families are asked to provide ongoing feedback. Individuals/families are encouraged and responsible to contact the DD Case Manager/Support Broker whenever necessary to address problems or issues or to modify the Case Plan/service agreement.

The Quality Enhancement Review protocol provides for review by the Regional DD Program Administrator and Central Office Administrators if issues are not resolved at the consumer/family DD Case Management/Support Broker level. All Quality Enhancement reviews are in an electronic file that is viewable at the central office and are sampled when Central Office Administrators conduct reviews for Licensure of Regional DD Case Management services.

All incidents of alleged abuse, neglect and exploitation must be reported in accordance with state policies.

On an annual basis, the DD Case Manager/Support Broker will complete the System Indicator questionnaire with the individual/family. The System Indicator is an interview designed to determine how well the Developmental Disabilities Service system is performing in various areas. The data collected through System Indicators will be analyzed by the Disability Services Division (state DD Unit) to determine trends within the system and used in system planning, quality assurance and improvement activities.

The Department of Human Services tracks Strategic Measures on a quarterly basis. DD Case Management databases are queried at the central office to create reports such as percentage of individual outcomes achieved, service utilization, availability of supports, and percentage of children remaining in family home settings. The databases also track timely completing of required DD Case Management activities. Data is routinely shared with regional case management staff and the state DD Advisory Council.

The state DD Advisory Council will be asked to review Policies, procedures and data regarding the Self Directed Supports program and make recommendations to DD Central Office Administrators regarding refinement and improvement.

APPENDIX F-2 ANNUAL REPORTS

A summary of the results of the State's monitoring of recipient health and welfare and the continuous improvement of waiver program operations will be submitted annually, as part of the CMS approved reporting forms/process.

APPENDIX G – FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW AND DEMONSTRATION OF
COST NEUTRALITY FORMULA

LEVEL OF CARE: **ICF/MR**

Definitions:

(NOTE: A separate chart should be filled out for every level of care in the waiver program. The State should also include a chart reflecting the weighted average of the combined levels of care offered in the program.)

Factor D Estimated annual average per capita Medicaid cost for Home and Community-Based Services for individuals in the waiver program.

Factor D' Estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program

Factor G Estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted.

Factor G' Estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Col. 1 Year	Col. 2 Factor D	Col. 3 Factor D'	Col. 4 Total: D+D'	Col. 5 Factor G	Col. 6 Factor G'	Col. 7 Total: G+G	Col. 8 Difference (subtract column 4 from column 7)
1	**6,538.20**	**3,067**	**9,605.20**	**110,312**	**3,653**	**113,965**	**104,359.80**
2	**6,538.20**	**3.067**	**9,605.20**	**110,312**	**3,653**	**113,965**	**104,359.80**
3	**6,538.20**	**3.067**	**9,605.20**	**110,312**	**3,653**	**113,965**	**104,359.80**
4							
5							

If states elect to consider Supports Brokerage and/or Fiscal/Employer Agent Services/Functions administratively rather than as wavier services, these costs and the methodology used to calculate the costs must be identified.

Service	Estimated Costs	Methodology Description
Fiscal Agent	**$1200/person/yr**	**Estimate based on information for current Fiscal Agents. Actual costs will be determined after RFP process.**
Support Broker	**Average of 32 units per year per user at $72 per unit/hour**	**Estimate based on information for current Case Management**

APPENDIX G-2 - DERIVATION OF ESTIMATES

NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS	EXPLANATION of ESTIMATE of NUMBER of UNDUPLICATED INDIVIDUALS SERVED:
1	**30**	**The estimate is based on trend data regarding the increase in the number of families accessing excess child care through the Family Subsidy program.**
2	**30**	
3	**30**	
4		
5		

FACTOR D: AVERAGE COST OF WAIVER SERVICES

Year 1				
Waiver Service (Add row for each service)	**# Users**	**Avg. Units/User**	**Avg. Cost/Unit**	**Total Cost**
Primary Caregiver Assistance	**25**	**492**	**$12.40/hr**	**$152,250.00**
Employment Support	**10**	**354**	**$12.40/hr**	**$43,896.00**
GRAND TOTAL:				**$196,146.00**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				**30**
FACTOR D (Divide total by number of recipients)				**$6,538.20**

Year 2				
Waiver Service (Add row for each service)	**# Users**	**Avg. Units/User**	**Avg. Cost/Unit**	**Total Cost**
Primary Caregiver Assistance	**25**	**492**	**$12.40/hr**	**$152,250.00**
Employment Supports	**10**	**354**	**$12.40/hr**	**$43,896.00**
GRAND TOTAL:				**$196,146.00**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				**30**
FACTOR D (Divide total by number of recipients)				**$6,538.20**

Year 3				
Waiver Service (Add row for each service)	**# Users**	**Avg. Units/User**	**Avg. Cost/Unit**	**Total Cost**
Primary Caregiver Assistance	**25**	**492**	**$12.40/hr**	**$152,250.00**
Employment Support	**10**	**354**	**$12.40/hr**	**$43,896.00**
GRAND TOTAL:				**$196,146.00**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				**30**
FACTOR D (Divide total by number of recipients)				**$6,538.20**

PROJECTED AVERAGE LENGTH OF STAY IN WAIVER PROGRAM:

338 days (derived from 372 reports).

Please provide a narrative description and supporting documentation for the derivation of the following factors:

FACTOR D DERIVATION: Based on Factor D arrived at on page 34, 35 and 36 for Year 1, Year 2 and Year 3.

FACTOR D' DERIVATION: From year five of HCBS Waiver (ND-0037.90.R3.02). Did not trend forward as legislative appropriation may not include inflationary increases.

FACTOR G DERIVATION: From year five of HCBS Waiver (ND-0037.90.R3.02). Did not trend forward as legislative appropriation may not include inflationary increases.

FACTOR G' DERIVATION: From year five of HCBS Waiver (ND-0037.90.R3.02). Did not trend forward as legislative appropriation may not include inflationary increases.

Appendix G-3 METHOD OF PAYMENTS (check one):

X Payments for all waiver and State plan services will be made through an approved Medicaid Management Information System (MMIS).

____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will make payments and maintain an audit trail is attached to this Appendix.

_____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which the State will make payments and maintain an audit trail is attached to this Appendix.

Appendix G-4 – INDIVIDUAL BUDGET PROJECTIONS OF RESOURCES WITHIN THE EXCLUSIVE CONTROL OF THE FAMILY OR THE INDIVIDUAL. (This information is required, but will not be used in the calculations of cost neutrality.)

Please estimate the proportion of families or persons who will have annual individual budget amounts in the following ranges**:**

Budget Range	Proportion of Participants
$1 – 5,000	**45**
$5001 – 10,000	**35**
$10,000 – 15,000	**10**
$15,001 – 20,000	**2**
$20,001 – 25,000	**2**
$25,001 – 50,000	**2**
$50,000 – 75000	**2**
$75,001 – 100,000	**1**
$100,000 and above	**1**
	100%

APPENDIX H – INDIVIDUAL BUDGETS

The following describes in detail EITHER:

The State's uniform methodology for the calculation of individual budgets, OR

The criteria and approval process for entities with which the State has contracted for day-to-day operations of the program.

This description addresses the minimum requirements that the methodology utilize actual service utilization and cost data, how the methodology is explained to the family or individual, the re-determination process, and how the methodology is open to public inspection.

DD Case Managers/Support Brokers will negotiate individual budgets to meet needs identified through the person centered planning process. Individual budgets will not exceed:

- **300 hours of Primary Caregiver Assistance per month.**
- **30% of hours worked per month for Employment Support for individuals for whom funding is not available under a program funded by either the Rehabilitation Act of 1973 or Public Law 94-142.**

The following information will be included in training material for Support Brokers and families, as well as being made available on the web. The material will not be finalized until after our waiver application is approved. We are also interested in reviewing material from others States that addresses family supports.

In addition to the disability related needs of the eligible client the families strengths and needs must also be considered in determining the amount of Primary Caregiver Assistance that will be authorized through the Individual Budget. The family's current stress and prevention of stress that might lead to the child being placed out of the home must be considered. Support Brokers need to work closely with families to help them determine their stress level and to explore all options, in addition to DD funded supports, that might increase their coping ability. Factors to consider include informal supports available to the primary caregiver: the amount of time the family member with a disability is out of the home (school or day supports, etc.); the medical, behavioral or personal care needs of the eligible client; physical demands in providing care (lifting/transfers), the need for specially training caregivers and the needs of other family members that the primary care is also responsible for.

The hourly rate used to determine the individual budget amount for Primary Caregiver Assistance and Employment Supports will not exceed a maximum hourly rate established by the Department of Human Services. Although a standard hourly rate will be used to determine the budget amount for Primary Caregiver Assistance and Employment Support, the consumer will have the flexibility to negotiate the rate at which they will compensate their selected providers.

If the individuals documented needs exceed the budget limits, the DD Case Manager/Support Broker may request an exception from the Disabilities Services Division (DD Unit) of the ND Department of Human Services.

To ensure consistency, Individual budgets will be entered in a Lotus Notes Database. Through a workflow and approval process, the database tracks the individual budgets from the DD Case Manager/Support Broker, through the Regional DD Program Administrator, to the state level central office administrator. Edits are built into the database to prevent errors. The database also calculates total funds authorized and tracks areas in which funds are allocated. At the end of a budget period the database is updated to reflect actual funds expended.

Self Directed Support Authorizations/Individual Budgets will contain information regarding the consumer/legal guardian's rights if supports are suspended, terminated or reduced. See Self Directed Supports Authorization Template Attachment.

APPENDIX I – PARTICIPANT PROTECTIONS

The state procedures and processes to assure that each of the following protections is in place are described below:

The state has procedures to assure that families and individuals have the requisite information and/or tools to participate in a family or person-centered planning approach and to direct and manage their care as outlined in the individual plan of care. The state will make available and provide services such as assistance in locating and selecting qualified workers, training in managing the workers, completing and submitting paperwork associated with billing, payment and taxation. Such functions are mandatory under the template and should be provided by one or more entities. When these functions are delivered as waiver services the provider qualifications are described in Appendix B.

Regional DD Case Managers/Support Brokers will give the individual/family a choice between the traditional waiver program, Medicaid State plan and the new self-directed services model and will describe the benefits and limitations of the different programs relative to the individual's/family's needs.

Once the individual/family has expressed interest in participating in the self-directed services model, the DD Case Manager/Support Broker will:

- **Describe the service planning process and implementation of the person-centered plan.**
- **Provide information on worker qualifications and identification of possible providers, including people known to the family such as extended family, neighbors, existing agency/individual qualified service providers, and others in the local community if the individual/family does not have a worker in mind.**
- **Provide information on interviewing, supervising, managing and evaluating workers.**
- **Describe the role of the support broker and oversight of services provided under the waiver.**
- **Identify the responsibilities of providers and family members in the provision of services and supports.**
- **Describe of the role of the Fiscal agent (conducting criminal background checks, managing consumer budgets and disbursement, time sheets, disbursing payroll including computation of with holdings, filing and depositing employment taxes, generating standardized reports.)**
- **Describe how the individual budget is developed.**
- **If applicable, provide an explanation of alternative approaches to behavioral intervention, including a description of theory, practice, strengths and expected outcomes of the methods;**

Upon family or individual request, the state will make available at no cost, provider qualification checks, including criminal background checks.

The Fiscal Agent will conduct criminal background checks on all people, including family members and friends, who are being considered for as an independent provider for Primary Caregiver Assistance. The criminal background check will be obtained at no cost to the individual/family. The individual/family may hire staff contingent upon the criminal background check for a period not to exceed 60 days.

The State has procedures to promote family or individual preferences and selections and these are appropriately balanced with accepted standards of practice. This balance requires deference to the preferences of the individual whenever possible. Procedures may include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

Individual/family choice and control will be a prominent aspect of North Dakota's Self-Directed Services Waiver. Individuals and families will be fully involved in the needs assessment process and services will be specifically tailored to the competencies, interests, preferences and needs of the individual and his or her family and respectful of the cultural and ethnic beliefs, traditions, personal values and lifestyle of the individual/family. The individual/family will train the provider on specific needs of the individual and will determine whether skill competencies are met. In assuming these responsibilities the individual/family will necessarily takes on risk that was previously assumed by provider agencies and program managers. Responsiveness to individual/family preferences and requests will occur within the context of state and federal laws and regulations and policies of the Department of Human Services/DD Unit. Case Plans/person centered plans with the individual/family will document not only consumer choice and control but also responsibilities of the different parties involved in the service arrangement and compliance with laws and regulations.

The State has a viable system in place for assuring emergency back up and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the State also has system procedures in place.

The consumers Person Centered Plan will address plans for what will happen if the primary caregiver is unable to perform their role. This will be very individualized and may include other family members or friends, formal supports or generic community supports. If difficulty is encountered during the implementation of the emergency plan the Support Broker or a representative from their agency will be available to assist in accessing emergency supports. If the emergency occurs during hours when staff is not available at a regional Human Service Center, the emergency crisis line available in all regions can be accessed for support. Because

the above steps will be described in detail in the individual's Person Centered Plan they will be aware of how to contact the Human Service Center and the regional crisis line.

The State has procedures for how it will work with individuals/families and their employer agents (if applicable) to monitor the ongoing expenditures of the individual budgets.

The DD Case Manager/Support Broker will review and monitor the actual expenditures of the individualized budget and assist the individual/family in managing the authorized funds. This review will be based on a monthly financial report generated and maintained by the Fiscal Agent

The State has procedures for how it will handle those instances where this ongoing monitoring has failed to prevent the expenditure of the individual budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the health and welfare of the individual are available.

If unforeseen circumstances or an emergency occurs and the individual budget amount will not meet the clients need, the DD Case Manager/Support Broker can request an individual budget addendum to augment the individual budget. In such cases, the DD Case Manager/Support Broker will need to submit to the Regional DD Program Administrator, documentation providing information regarding the nature of the problem and the specific breakdown of the additional costs. If the individuals documented needs exceed the budget limits, the DDCM/SB may request an exception from the Disabilities Services Division (DD Unit) of the ND Department of Human Services.

The State has procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination.

At the conclusion of each quarterly budget period, all unspent resources will be returned to the system for re-authorization during the next budget cycle. Individuals will not be allowed to carry over under-expended funds from one quarter to the next. Consumers will plan with their Support Broker for expected one-time expenses that can then be included in the budget during the appropriate time frame.

The State has a viable system by which is receives, reviews and acts upon critical events or incidents (states must describe critical events or incidents). This system may include an existing process (e.g., child or adult protective services). This system must be part of the Quality Assurance and Improvement Program.

See attached policy (DDD-PI-006)